

00-13864

STATE OF MARYLAND										21248																					
FOR Item 18 11-17-86 cn DEPARTMENT OF HEALTH AND MENTAL HYGIENE 6										REG. NO.																					
1- STATE REGISTRAR																															
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																															
1. DECEASED NAME (TYPE OR PRINT)			2. DATE KNOWN OF DEATH			3. MONTH			4. DAY			5. YEAR			6. HOUR			7. MINUTE													
Fairlee			Chester			7			12			1986			5			58 PM													
8. SEX		9. RACE		10. DATE OF BIRTH		11. AGE (IN YEARS)		12. IF UNDER 1 YR.		13. IF UNDER 24 HRS.		14. DATE PRONOUNCED DEAD		15. MONTH		16. DAY		17. YEAR		18. HOUR		19. MINUTE									
Female		Blk		9 5 29		56 YRS.						7		12		1986		5		58 PM											
20. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				21. CITIZEN OF WHAT COUNTRY?				22. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				23. BALTIMORE CITY OR COUNTY OF DEATH				24. MD															
Md				USA								Talbott																			
25. CITY OR TOWN OF DEATH				26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								27. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				28. KIND OF BUSINESS OR INDUSTRY															
Easton				Easton Mem Hosp								None																			
29. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				30. STATE				31. CITY OR TOWN				32. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				33. STREET ADDRESS															
Md				Talbott				Easton				YES				Route 1, Box 503															
34. FATHER'S NAME				35. MOTHER'S MAIDEN NAME				36. SOCIAL SECURITY NO.				37. INFORMANT				38. ADDRESS															
William				Maggie Bolden				217-54-5177				Elva				Nichols															
39. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				40. SOCIAL SECURITY NO.				41. INFORMANT				42. ADDRESS				43. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
No				217-54-5177				Elva				Nichols																			
44. CAUSE OF DEATH (Enter only one cause per part)										45. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART I DEATH WAS CAUSED BY:										PNEUMONIA																					
IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause first										(b)																					
										DUE TO, OR AS A CONSEQUENCE OF																					
										(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																															
46. DATE OF OPERATION										47. CONDITION FOR WHICH OPERATION WAS PERFORMED?										48. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
49. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										50. TIME OF INJURY HOUR A.M. MONTH DAY YEAR										51. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
										P.M. 19																					
52. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										53. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										54. LOCATION STREET CITY OR TOWN COUNTY STATE											
55. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										56. Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																					
57. ACTUAL SIGNATURE										58. TITLE (SPECIFY)										59. DATE SIGNED											
R. Paul Wright										M.D. Wright										7-15-86											
60. EXAMINER'S NAME (TYPE OR PRINT)										61. ADDRESS																					
62. BURIAL, CREMATION, REMOVAL										63. DATE										64. NAME OF CEMETERY OR CREMATORY										65. LOCATION CITY OR TOWN COUNTY STATE	
										7/18/86										Richardson Cem										Easton TA. Md	
66. FUNERAL DIRECTOR										67. DATE REC'D. BY REGISTRAR										68. REGISTRAR'S SIGNATURE											
George H. Deas										JUL 30 1986										Julia Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 236
DHMH - 17
(VR A15 ME (5))

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Q302

TOO 2202

(F)

00-11653

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 21249

FOR
STATE
REGISTRAR
June E. Dawson

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JUNE E DAWSON		2a. DATE OF DEATH MONTH 7 DAY 5 YEAR 86 th HOUR 3 ¹⁵ P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 17, 1926	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	6. AGE (IN YEARS (LAST BIRTHDAY)) 60 YRS.	
10. CITY OR TOWN OF DEATH EASTON		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT County MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. CITY OR TOWN Queen Annes	
13c. COUNTY Queen Annes		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rt. 1 Box 247 Q 21658		13f. STREET ADDRESS / ZIP CODE Rt. 1 Box 247 Q 21658	

14. FATHER'S NAME FIRST MIDDLE LAST Edward Ellis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Wannennwetsch	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-20-1999	
17. INFORMANT ADDRESS Queenstown, MD. 21658 Stanley Dawson - Rt. 1 Box 247 Q			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Electro-mechanical dissociation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins.
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction		hours
DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Artery Disease		years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-5-86 to 7-5-86 that (I/we) last saw the deceased alive on 7-5-86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we) did (did not) view the body after death.							
22b. SIGNATURE Dr. Faunteroy				DEGREE MD		22c. DATE SIGNED 7-5-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Faunteroy				22e. ADDRESS Easton Maryland			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD.	
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Ave., Catonsville MD. 21228				25a. DATE REC'D. BY REGISTRAR JUL 8 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, there is any injury, or other traumatic event, the medical examiner will be notified of this.



00-12269

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 21250

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DONALD JAMES ELL			2a. DATE OF DEATH MONTH DAY YEAR JULY 9, 1986			2b. HOUR 6:00a.m.				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 10 - 25 - 26		6. AGE (IN YEARS LAST BIRTHDAY) 59		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT				
10. CITY OR TOWN OF DEATH CORDOVA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 158, Skipton Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY DUPONT CHEMICALS		
13a. STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN CORDOVA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 158, Skipton Road 21625	
14. FATHER'S NAME FIRST MIDDLE LAST ADOLPH ELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE HESCHLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. W.W.I. 165-20-0749		17. INFORMANT ADDRESS LEE H. ELL, CORDOVA, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) recurrent lung carcinoma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Aug 4-8 19 86 to July 9 19 86 , that (I) (we) last saw the deceased alive on July 9 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE R.B. Sanchez						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-9-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.B. Sanchez						22e. ADDRESS 322 Commerce Dr Easton, MD				
23a. BURIAL, CREMATION, REMOVAL (SPEC) BURIAL			23b. DATE 7-12-86		23c. NAME OF CEMETERY OR CREMATORY OLD WHITEMARSH			23d. LOCATION CITY OR TOWN COUNTY STATE TRAPPE TALBOT MD		
24. FUNERAL DIRECTOR NAME NEWNAM FUNERAL HOME,						ADDRESS EASTON, MD.		25a. DATE REC'D. BY REGISTRAR JUL 14 1986		
25b. REGISTRAR'S SIGNATURE [Signature]										

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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ITWW

Handwritten text, possibly a signature or name.

Handwritten text, possibly a date or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO.		8 6 2 1 2 5 1							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		
DORA FAIRBANK						7-20-86			2b. HOUR 12:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cau.		September 7, 1900		85 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				TALBOT MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
EASTON		MEMORIAL HOSPITAL				Ck		Post office			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Maryland			Talbot			Bozman			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE					
FIRST MIDDLE LAST			FIRST MIDDLE LAST			Quaker Neck Road 2 1612					
William Richardson			Lillie McQuay								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		214-30-8705 A		R. Douglas Fairbank, Wittman, Md.		21676					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct.</u>										hours	
DUE TO, OR AS A CONSEQUENCE OF <u>Intermittent Heart Disease</u>										years	
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION			CITY OR TOWN COUNTY STATE		
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK											
22a. I certify that (I) (the hospital) attended the deceased from <u>8-26</u> , 19 <u>82</u> , to <u>July 20</u> , 19 <u>86</u> , that (I) (we) lost <u>save the deceased alive on July 20 19 86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			22c. DATE SIGNED					
<u>Richard F. Manegold</u>						7-20-86					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
RICHARD F. MANEGOLD, M.D.			115 Bay St., Easton, Maryland 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE		
Burial			July 23, 1986		Bozman Cemetery		Bozman		Talbot Maryland		
24. FUNERAL DIRECTOR			25. TIME OF DEATH			26. SIGNATURE					
<u>William E. Leonard</u>			<u>7:28 1986</u>			<u>John Benson-Radner</u>					

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Ante. Invenit. Invenit. Invenit.
Ante. Invenit. Invenit. Invenit.

Ante. Invenit. Invenit. Invenit.
Ante. Invenit. Invenit. Invenit.

Ante. Invenit. Invenit. Invenit.

00-11863

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 2 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HATTIE M. FELTON			2a. DATE OF DEATH MONTH DAY YEAR 7-3-86			2b. HOUR MIN. 705P				
3 SEX F		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 1 14 1927		6 AGE (IN YEARS LAST BIRTHDAY) YRS 49		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10 CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md 13b COUNTY GA					13c CITY OR TOWN CROSBYVILLE		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE Bx 89 21638	
14 FATHER'S NAME FIRST MIDDLE LAST Linwood JACKSON					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie CRUM					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Irving Felton Bx 89 Crosbyville Md			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA BRONCHUS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEPT. 1983										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a NONE										
19a DATE OF OPERATION 9-21-83			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE 7/2/86 7/3/86		21g I certify that (I) (this hospital) attended the deceased from 7/2/86 19____, to 7/3/86 19____, that (I) (we) last saw the deceased alive on 7/3/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22a SIGNATURE C. R. W. BAIN					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 7-4-86		
22d PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. BAIN					22e ADDRESS 14 N- AURORA, EASTON, Md.					
23a BURIAL, CREMATION, REMOVAL (SPEC) B			23b DATE 7-8-86		23c NAME OF CEMETERY OR CREMATORY Rollins		23d LOCATION CITY OR TOWN COUNTY STATE CROSBYVILLE GA MD			
24 FUNERAL DIRECTOR NAME ERIC L. Dashiell ADDRESS P.O. B 606 EASTON					25a DATE REC'D. BY REGISTRAR 9 1986		25b REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Handwritten notes and sketches, including a circular diagram with internal markings and various scribbles.

00-11912

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 is marked, any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 1 2 5 3	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leon T Colt					2a. DATE OF DEATH MONTH DAY YEAR 7/5/86			2b. HOUR 938 AM			
3. SEX m		4. RACE w		5. DATE OF BIRTH MONTH DAY YEAR 11 - 17-12		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital @ Easton md				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST URBAN THOMAS GOLT					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY K. FAVINGER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II		17. INFORMANT 577-20-3296		ADDRESS Margaret L. Golt, Easton, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) none APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION ---		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ---				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR --- 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) ---		21f. LOCATION STREET CITY OR TOWN COUNTY STATE ---							
22a. I certify that (I) (this hospital) attended the deceased from 7/5/86 to 7/5/86 that I (we) lost the deceased alive on DOA and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Albert T. Dawkins Jr MD					22c. DATE SIGNED 7/5/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKENS JR MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 7-8-86		23c. NAME OF CEMETERY OR CREMATORY St. Peters Church Cemetery Queenstown, Queen Anne, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Queenstown, Queen Anne, Md.		
24. FUNERAL DIRECTOR NAME NEWMAN FUNERAL HOME, EASTON					ADDRESS MARYLAND		25a. DATE REC'D. BY REGISTRAR JUL 9 1986				
							25b. REGISTRAR'S SIGNATURE Julia Davidson				

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

2 1 2 5 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John F. FRANCIS Haddaway		2a DATE OF DEATH MONTH DAY YEAR 7 4 86		2b HOUR 6:58 M
3 SEX MALE	4 RACE CAUC.	5 DATE OF BIRTH MONTH DAY YEAR JULY 30, 1918	6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.	
10 CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memoria	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEXTON CHRIST CHURCH	12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND		13b COUNTY TALBOT	13c CITY OR TOWN ST. MICHAELS	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST JAMES FRANKLIN HADDAWAY		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN M. HADDAWAY		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17 INFORMANT ESTHER LUCILLE HADDAWAY	ADDRESS 109 MULBERRY ST. ST. MICHAELS, MD. 21663	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE AND ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) LUNG NEOPLASM				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (i) (this hospital) attended the deceased from 7/1 19 86 , to 7/4 19 86 , that (i) (we) lost saw the deceased alive on 7/4 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (ii) (we) (did) (did not) view the body after death.				
22b. SIGNATURE W. S. Bremer		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/7/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm S. BREMER MD		22e. ADDRESS ST. MICHAELS MD 21663		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE JULY 8, 1986	23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE HURL OCK DORCHESTER Md.	
25a. DATE REC'D. BY REGISTRAR 14 1986		25b. REGISTRAR'S SIGNATURE John Davidson		

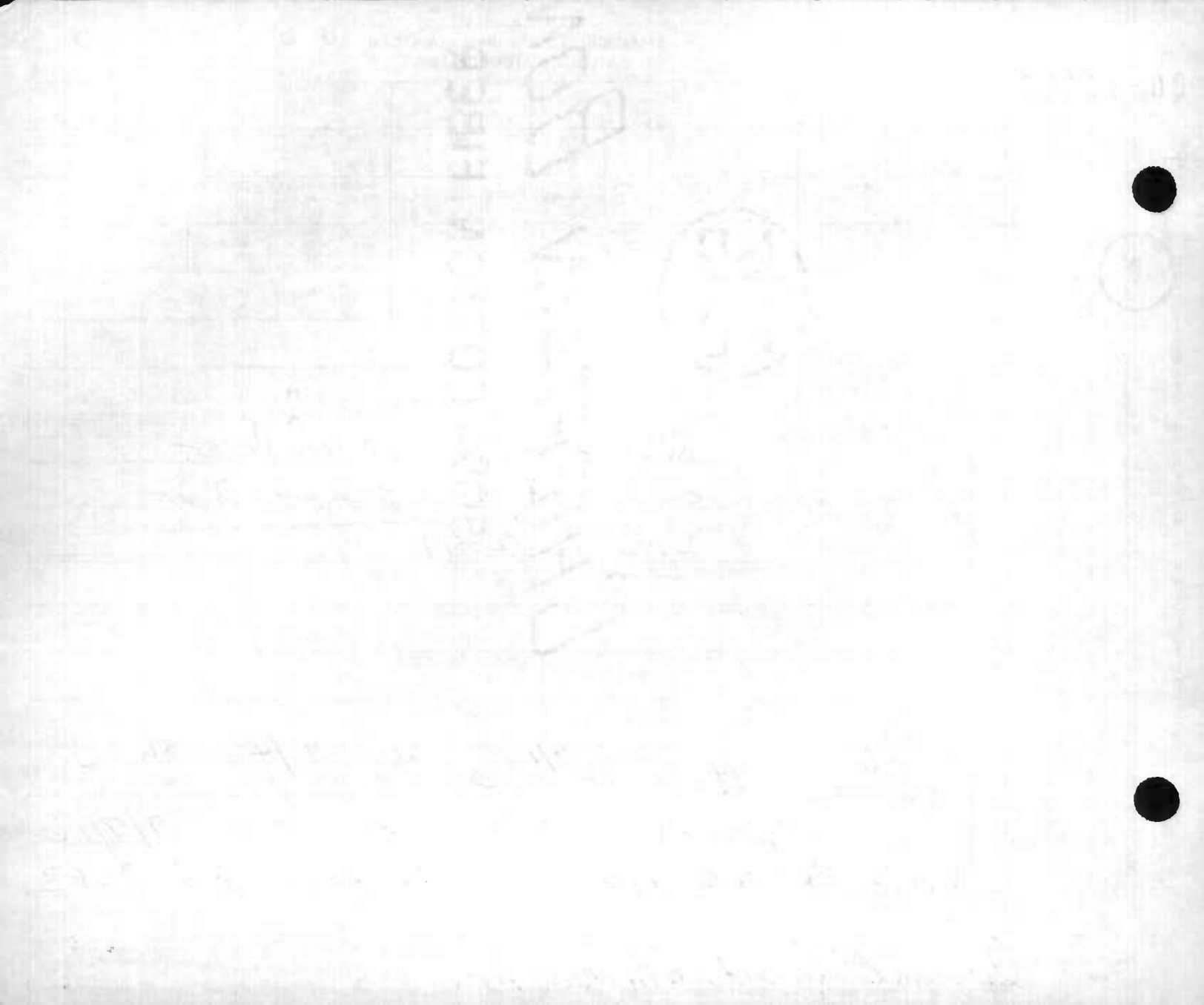
MEDICAL CERTIFICATION

7/8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a brief time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



00-13305

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 2 1 2 5 5	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ADA Jane HARRISON					2a. DATE OF DEATH MONTH DAY YEAR JULY 18, 1986			2b. HOUR 4:02 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 20 01		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD					
10. CITY OR TOWN OF DEATH Tilghman		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Gibsonstown Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Tilghman		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Gibsonstown Road 21671		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Ridgeway				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Sinclair							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-9331		17. INFORMANT ADDRESS Roberta Marshall P. O. Box 495 St Michaels MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <u>14 May 1986</u> to <u>19 July 1986</u> that (1) <u>we</u> last saw the deceased alive on <u>17 July 1986</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, <u>we</u> (we) (s) (d) <u>examined</u> the body after death.											
22b. SIGNATURE <u>R. Lane Wroth, M.D.</u>					DEGREE ATTENDING PHYSICIAN		MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-19-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.					22e. ADDRESS St. Michaels, MD 21663						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/21/86		23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sherwood Talbot MD				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home					ADDRESS Easton Maryland		25a. DATE REC'D. BY REGISTRAR JUL 24 1986		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

00-11913

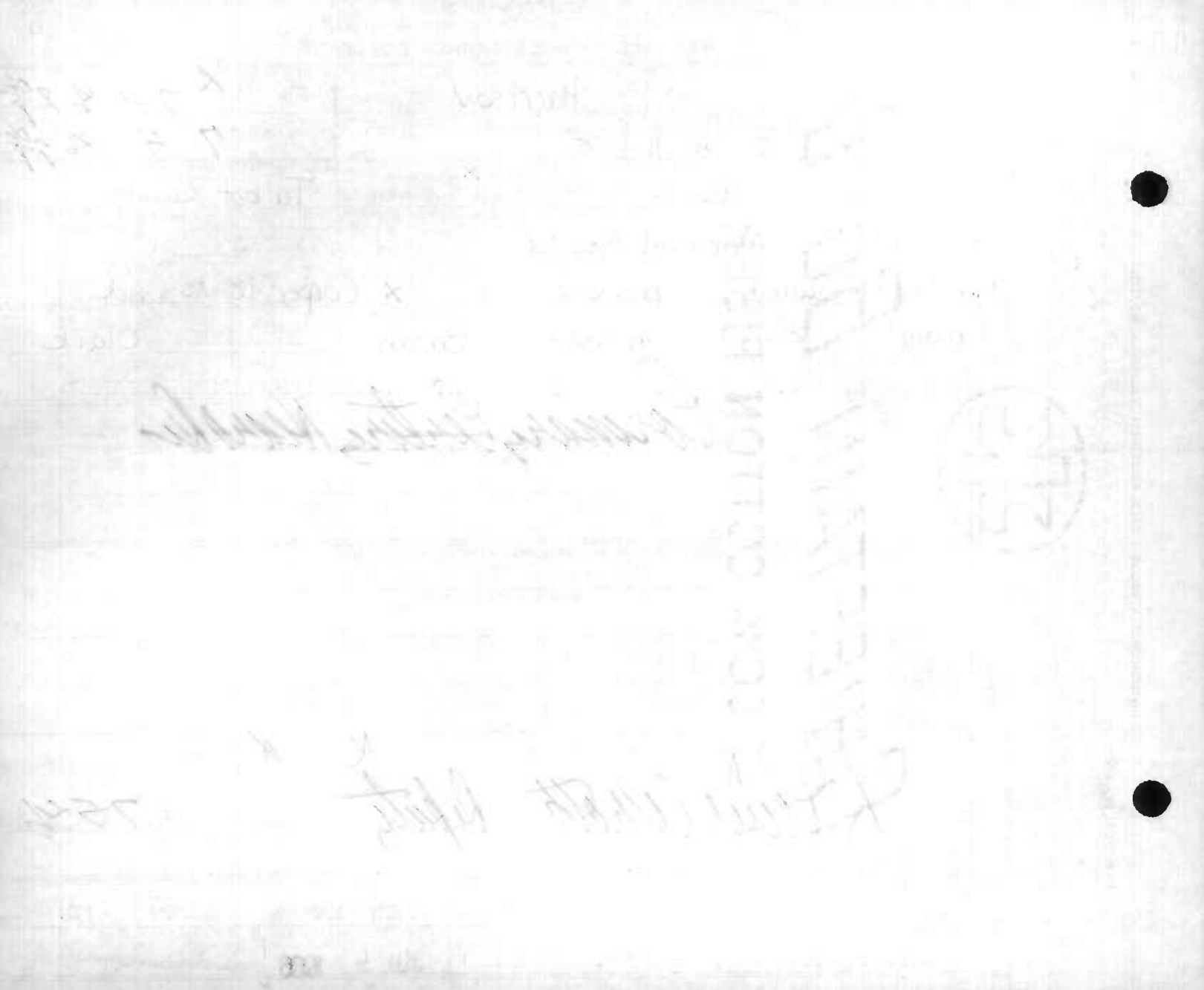
1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Earle O Harrison			2a. DATE KNOWN OF DEATH MONTH 7 DAY 4 YEAR 1986 HOUR 2 MIN 29			
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 5 DAY 20 YEAR 11	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YR MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 4 YEAR 1986 HOUR 2 MIN 29
BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County
10. CITY OR TOWN OF DEATH Bozman		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	
13a. STATE Maryland		13b. COUNTY Talbot	13c. CITY OR TOWN Bozman	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Cooper Points Road	
14. FATHER'S NAME FIRST Samuel MIDDLE FRANCIS LAST Harrison			15. MOTHER'S MAIDEN NAME FIRST Sarah MIDDLE ELIZABETH LAST Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. YES W.W. II 218-03-4056		17. INFORMANT CORA W. HARRISON, BOZMAN, MARYLAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) 						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE R. Lane Wroth		M.D. Deputy			MEDICAL EXAMINER DATE SIGNED 7-5-86	
EXAMINER'S NAME (TYPE OR PRINT) R. LANE WROTH, MD.		ADDRESS ST. MICHAELS, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-8-86		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE EASTON TALBOT MD.
24. FUNERAL DIRECTOR NAME ADDRESS NEWMAN FUNERAL HOME, EASTON, MARYLAND				25a. DATE REC'D. BY REGISTRAR JUL 9 1986		25b. REGISTRAR'S SIGNATURE John Darden

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

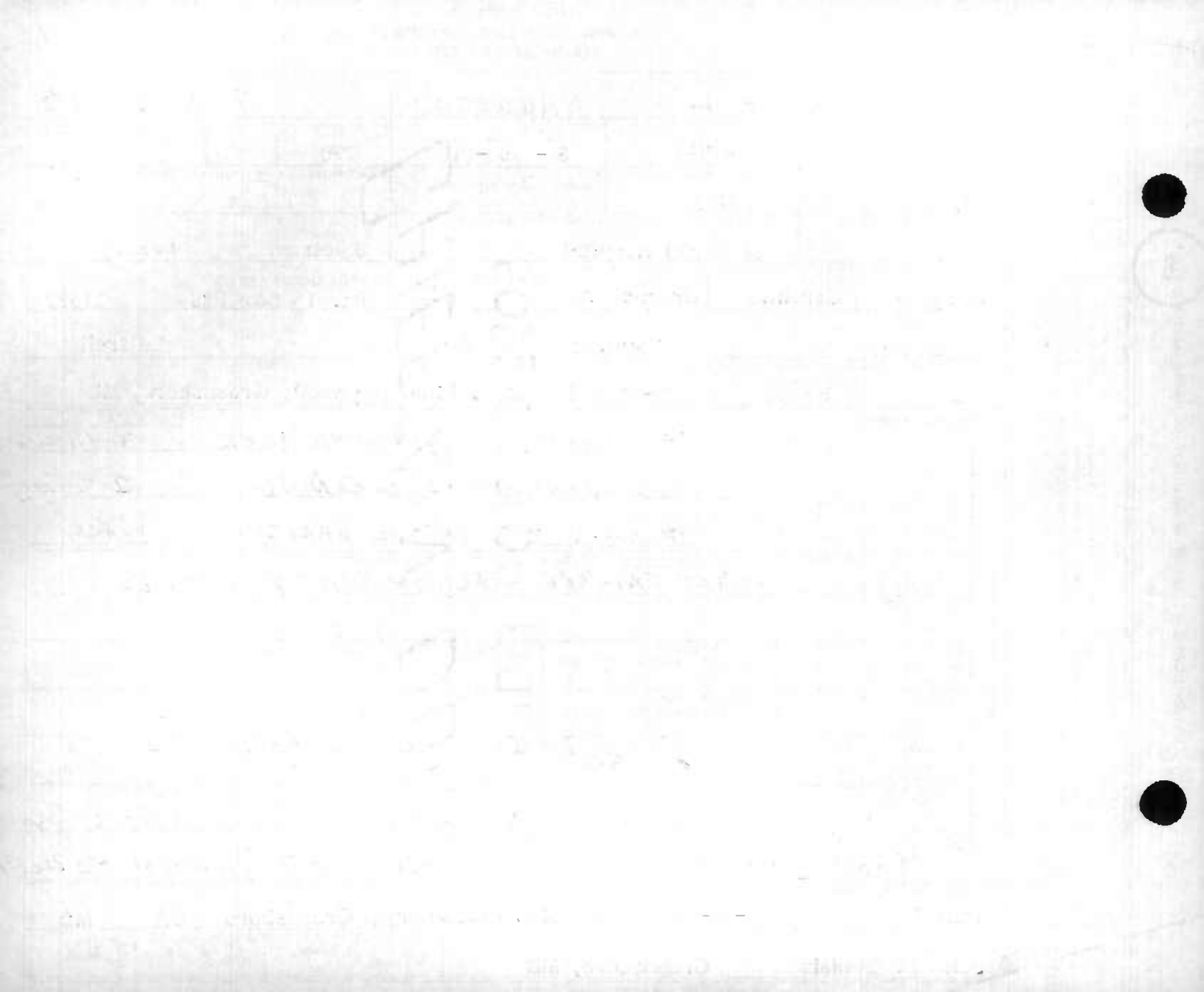
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WARING L. HAYWOOD			2a. DATE OF DEATH MONTH DAY YEAR 7 16 86		2b. HOUR 1:30 PM	
3. SEX M	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 - 16 - 16		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.		
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY bakery	
13a. STATE Maryland		13b. COUNTY Caroline	13c. CITY OR TOWN Greensboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George Haywood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Luttrell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Mrs. Lillie Haywood, Greensboro, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC + HYPOVOLEMIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (c) PROBABLY ESOPHAGEAL VARICES					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 hours 2-3 days YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a CONGESTIVE HEART FAILURE, CARDIOMYOPATHY, DIABETES						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-16 , 19 86 , to 7-16 , 19 86 , that (I) (we) last saw the deceased alive on 7-16 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.						
22b. SIGNATURE Mary Campagnolo MD		DEGREE MD		22c. DATE SIGNED 7-16-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARY CAMPAGNOLO, MD		22e. ADDRESS P.O. BOX 660, DENTON, MD 21629				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7-18-86		23c. NAME OF CEMETERY OR CREMATORY Greensboro Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Greensboro CA MD		25a. DATE REC'D. BY REGISTRAR JUL 21 1986				
24. FUNERAL DIRECTOR NAME John E. Boulais		ADDRESS Greensboro, MD		25b. REGISTRAR'S SIGNATURE Julia Sanders-Radcliffe		

BP



00-13048

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Michael

Herpers

2a. DATE KNOWN
OF DEATH
ESTI-
MATED

MONTH

DAY

YEAR

7-14-86

2b. HOUR

4:50

3. SEX

male

4. RACE

white

5. DATE OF BIRTH

11/9/69

6. AGE (IN YEARS
LAST BIRTHDAY)

16 YRS.

IF UNDER 1 YR.

MONTHS

DAYS

IF UNDER 24 HRS.

HOURS

MIN.

7c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

7-14-86

2d. HOUR

5:50

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

New York

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Talbot

10. CITY OR TOWN OF DEATH

Easton

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Easton Memorial Hosp.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

student

12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

A.A. Co.

13c. CITY OR TOWN

Severna Pk.

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

520 Stockbridge Ct.

14. FATHER'S NAME

Henry

MIDDLE

LAST

Herpers

15. MOTHER'S MAIDEN NAME

Billha

MIDDLE

LAST

Krug

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

no

16b. SOCIAL SECURITY NO.

N/A

17. INFORMANT

245-37-3647

ADDRESS

Henry Herpers

same as 13

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).
PART I DEATH WAS CAUSED BY:

8161

IMMEDIATE CAUSE (a)

Multiple Sclerosis
Cerebral CirculationConditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause lastDUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

4:30 P.M. 7-14-86

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I (a) (2))

Passenger in car that went off road

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒AT WORK ☐ AT WORK ☒21e. PLACE OF INJURY (AT HOME,
WORK, FACTORY, FARM, ETC.)

Highway

21f. LOCATION

Rt 50 Not far off Rd, Talbot Co. Md.

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☒

and in my opinion

death resulted from

Natural causes ☐Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

R. Lane Wroth M.D.

MEDICAL EXAMINER

DATE
SIGNED

7-15-86

EXAMINER'S NAME
(TYPE OR PRINT)

R. Lane Wroth M.D.

ADDRESS

23a. BURIAL, CREMATION, REMOVAL
(Specify)

Burial

23b. DATE

7/16/86

23c. NAME OF CEMETERY OR CREMATORY

Hillcrest Cemetery

23d. LOCATION
CITY OR TOWN

Annapolis

COUNTY

A.A. Co. STATE

Md.

24. FUNERAL DIRECTOR

Hardesty Funeral Home

ADDRESS

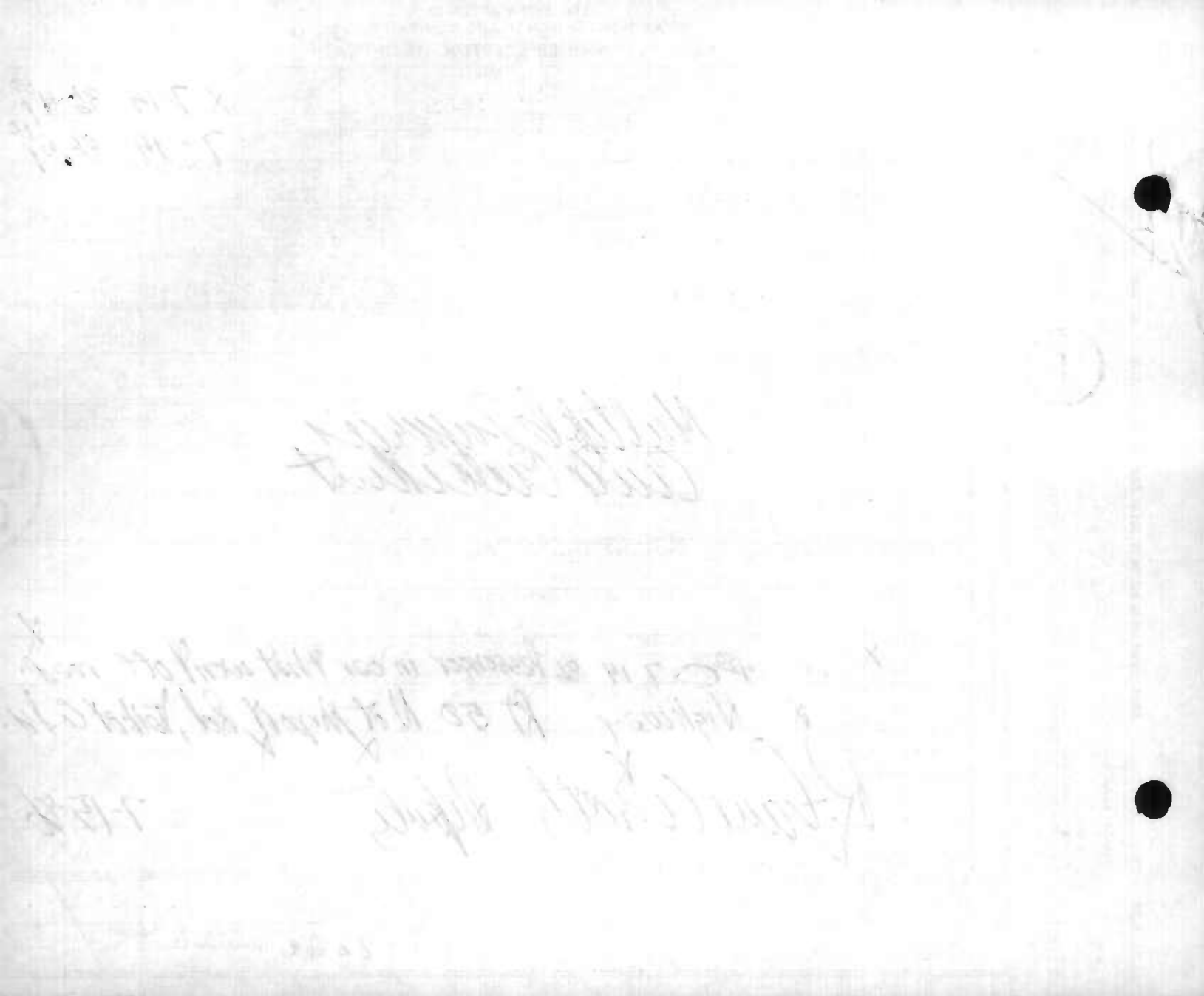
12 Ridgely Ave.
Ann. Md. 21401

25a. DATE REC'D. BY REGISTRAR

JUL 22 1986

25b. REGISTRAR'S SIGNATURE

John Davidson



00-12907

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "true," it shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 2 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leona J. Jones			2a. DATE OF DEATH MONTH DAY YEAR 7-6-86			2b. HOUR 9 A M			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR AUG. 28, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital @ Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN WITTMAN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 21676			14. FATHER'S NAME FIRST MIDDLE LAST CHARLES J. HADDAWAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NETTIE MARSHALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS ELMA MILLER WITTMAN, Md. 21676					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral arteriosclerosis								Uncertain	
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a None									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 6-25, 1986, to 7-6, 1986, that (1) (we) last saw the deceased alive on 7-6, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.									
22b. SIGNATURE Robert W. Trever, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7-7-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.					22e. ADDRESS RD3 Box 297 Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE JULY 9, 1986		23c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ST. MICHAELS, TALBOT Md.		
24. FUNERAL DIRECTOR NAME Shamus E. Leonard					25a. DATE REC'D. BY REGISTRAR JUL 14 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson		

00-13866

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETURN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 6 2 1 2 6 0	
1. DECEASED NAME (TYPE OR PRINT) Ann Keene							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 14 1986		2b. HOUR 2:16A		
3. SEX Female	4. RACE B1K	5. DATE OF BIRTH MONTH DAY YEAR 8 17 51	6. AGE (IN YEARS) LAST BIRTHDAY 35 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 7 14 1986		2d. HOUR 2:16A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County, MD					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Aide		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY Caroline		13c. CITY OR TOWN Federburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 402 Park Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Charles A Deshields				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bernitta Handy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-52-2201		17. INFORMANT Bernitta Deshields		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:45xx 7 14 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 402 Park Lane Federburg, Talbot, MD.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 7/14/86			
EXAMINER'S NAME (TYPE OR PRINT) William M. Zane, M.D.				ADDRESS 111 Penn St. Balto. MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/17/86		23c. NAME OF CEMETERY OR CREMATORY Ponce de Leon Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Preston Cor. MD			
24. FUNERAL DIRECTOR NAME [Signature]				ADDRESS [Signature]				25a. DATE REC'D. BY REGISTRAR JUL 30 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

00-13438

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 2 6 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Leona R. Koerper			2a. DATE OF DEATH MONTH DAY YEAR 7-9-86		2b. HOUR 8:32 AM	
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JAN. 16 1903		
6. AGE (IN YEARS LAST BIRTHDAY) 83		7. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton		
12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sec. Chrysler Automobile		13. KIND OF BUSINESS OR INDUSTRY		14. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE md. 15b. COUNTY Anne Arundel 15c. CITY OR TOWN ANNAPO LIS		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS / ZIP CODE 1018 Mast Line Rd. 21401		
18. FATHER'S NAME FIRST MIDDLE LAST JOHN SULLIVAN		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE RABADUE		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
21. SOCIAL SECURITY NO. 365-01-8028		22. INFORMANT MARJORIE HAIG		23. ADDRESS P.O. Box 1000 Steven'sville Cove Creek Club, md 21666		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSELEBOTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 6 MONTHS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)						
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		25c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
26a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/7/86		26c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
27a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION STREET CITY OR TOWN COUNTY STATE		
28. I certify that (I) (this hospital) attended the deceased from 7/7/86 19____ to 7/9/86 19____, that (I) (we) lost saw the deceased alive on 7/9/86 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
29a. SIGNATURE C R W BAIN		29b. DEGREE MD		29c. DATE SIGNED 7/9/86		
30a. PHYSICIAN'S NAME (TYPE OR PRINT) C R W BAIN		30b. ADDRESS Easton, Md. 21601		30c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
31a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		31b. DATE 11 JULY 86		31c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		
32a. FUNERAL DIRECTOR NAME BEAL-EVANS FUNL. Home		32b. ADDRESS ANNAPO LIS, md 21401		32c. DATE REC'D. BY REGISTRAR JUL 25 1986		
33a. REGISTRAR'S SIGNATURE John Davidson-Hordale		33b. REGISTRAR'S SIGNATURE		33c. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

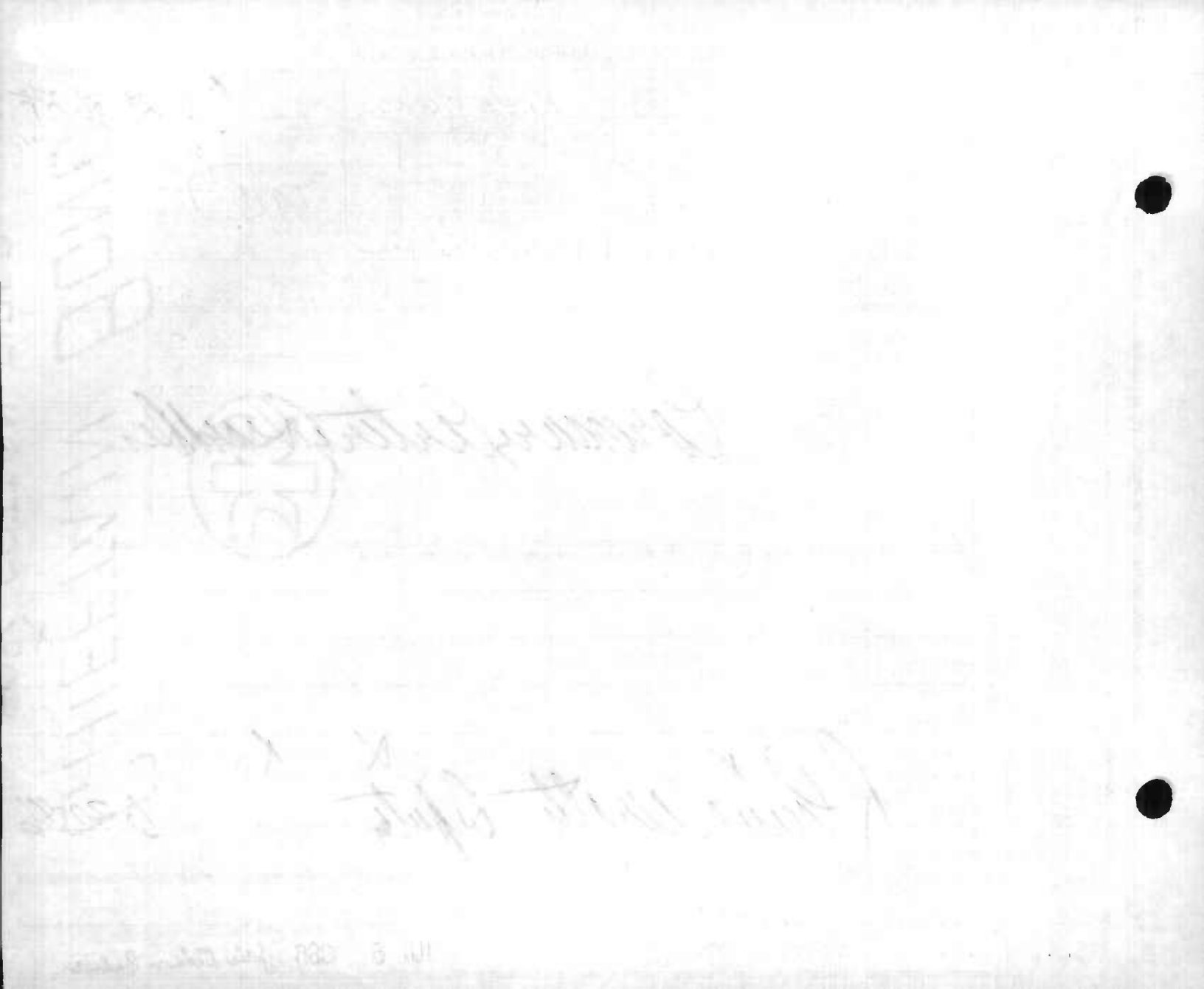
1. DECEASED NAME (TYPE OR PRINT)		FIRST Russell		MIDDLE		LAST Kreeger		REG. NO.		2a. DATE KNOWN OF DEATH		ESTI. MATED		MONTH 6		DAY 29		YEAR 1986		2b. HOUR 2:48			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-21-09		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR 6 29 19 86		2d. HOUR 2:44									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Talbot											
10. CITY OR TOWN OF DEATH Easton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hosp Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Pennsylvania				13b. COUNTY York				13c. CITY OR TOWN Hanover				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS R.D. 3, Box 453				99999			
14. FATHER'S NAME FIRST MIDDLE LAST Augustus Kreeger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Mitzel																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 184-05-0599				17. INFORMANT ADDRESS Florence Kreeger, Hanover, Md.															
18. CAUSE OF DEATH (Enter only one cause per line for PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE R. Lane Wroth, M.D.				TIME (SPECIFY) M.D.				MEDICAL EXAMINER				DATE SIGNED 6-30-86											
EXAMINER'S NAME (TYPE OR PRINT) R. Lane Wroth, M.D.				ADDRESS St. Michaels, Md. 21663																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/2/86				23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Hanover, York, PA.											
24. FUNERAL DIRECTOR NAME ADDRESS W.V. Kenworthy, Hanover, PA.										25a. DATE REC'D. BY REGISTRAR JUL 6 1986				25b. REGISTRAR'S SIGNATURE Julia Anderson-Rudolph									

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS INDICATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))



0-13304

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 2 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SAMUEL ROBERT LEONARD, JR.			2a. DATE OF DEATH MONTH DAY YEAR July 18, 1986		2b. HOUR 16 48 M								
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR May 23 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.							
10. CITY OR TOWN OF DEATH St. Michaels		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 108 St Michaels Cottages				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Talbot		13c. CITY OR TOWN St Michaels		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 108 St. Michaels Cottages 21663	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Robert Leonard Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Wright										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 210-34-3705			17. INFORMANT Hilda B Leonard, St. Michaels MD							
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death Primary Cause: Myocardial Infarction Secondary Cause: Atherosclerosis Interval: 1 year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from 19 60 to 18 July 19 86, that (1) (was) lost since the deceased alive on 16 July 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) I (we) did not view the body after death.													
22b. SIGNATURE R. LANE WROTH, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-19-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 7/21/86		23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sherwood Talbot MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home						ADDRESS Easton, Maryland		25a. DATE REC'D. BY REGISTRAR JUL 24 1986		25b. REGISTRAR'S SIGNATURE			

CONFIDENTIAL



For many years, the people of the world have been suffering from the effects of the war.

It is a sad fact that the people of the world are still suffering from the effects of the war. The war has caused the death of millions of people and the destruction of many cities and towns. The people of the world are still suffering from the effects of the war.

- 13303

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 1 2 6 4

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Madeline Berg Lillard			2a. DATE OF DEATH MONTH DAY YEAR July 20-1986		2b. HOUR 9 56 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 05 27 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY DuPont	
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Oxford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 100 Benoni Ave 21654							
14. FATHER'S NAME FIRST MIDDLE LAST Frederick W. Berg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Strebb				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 221-01-5367		17. INFORMANT ADDRESS John F. Lillard, Jr. P. O. Box 365 Oxford MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/19 1980 to 7/20 1986 , that (I) (we) last saw the deceased alive on 7/19 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Wm H Wood				DEGREE MD		22c. DATE SIGNED 7/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood				22e. ADDRESS Easton MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/23/86		23c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oxford Talbot MD	
24. FUNERAL DIRECTOR NAME ADDRESS Newnam Funeral Home Easton MD 21601				25a. DATE REC'D. BY REGISTRAR JUL 24 1986		25b. REGISTRAR'S SIGNATURE John F. Lillard, Jr.	

MEDICAL CERTIFICATION

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 1).

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Liberty

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Internal Security (R)

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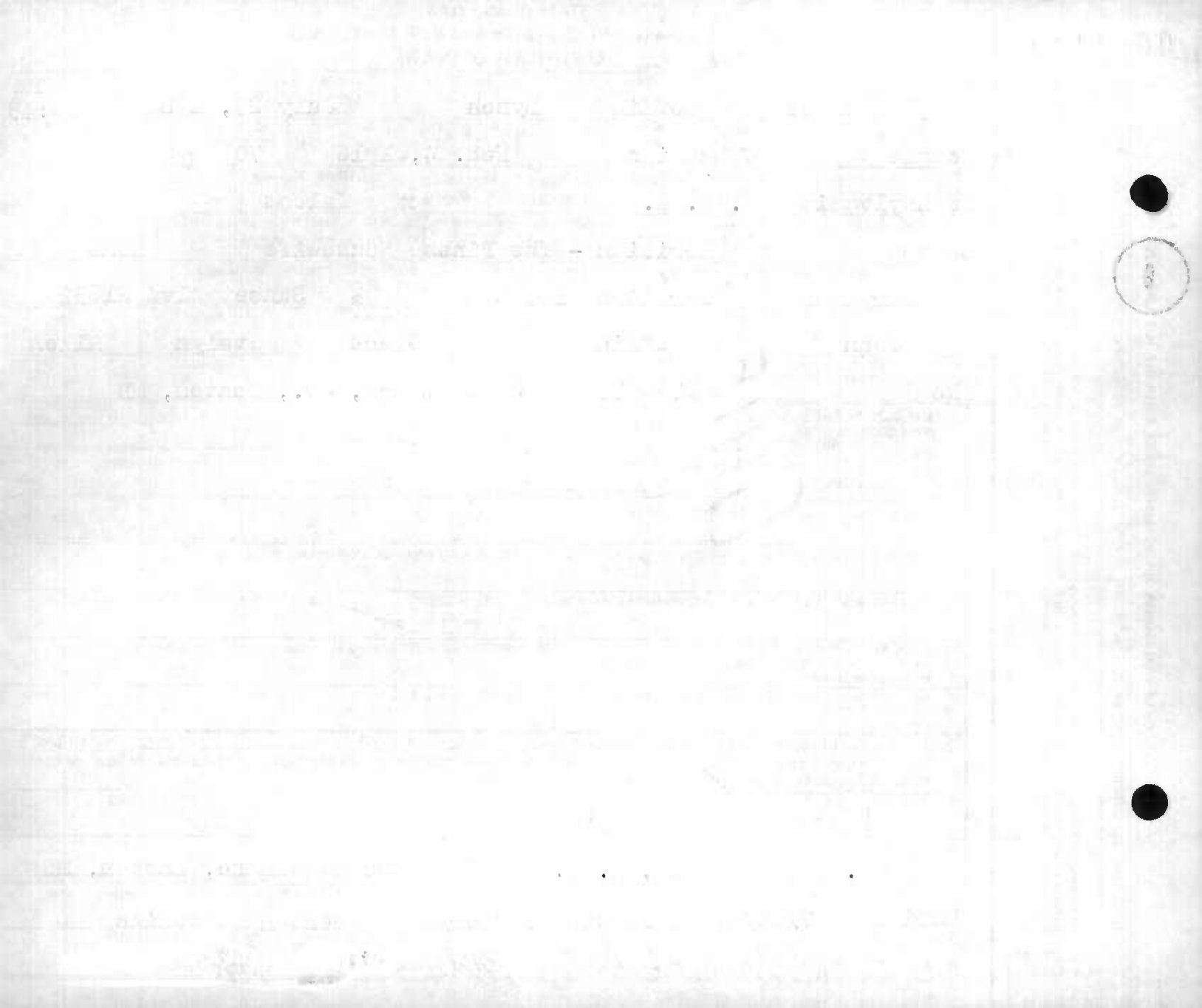
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

21265

1. DECEASED-NAME (Type or print) First Middle Last Grace Coffin Lynch			2a. DATE OF DEATH Month Day Year July 23, 1986		2b. HOUR 6:45 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH Feb. 4, 1916		6. AGE (In years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Talbot Md.		
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Meridian - The Pines	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Preston	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Sunset Blvd 21632	
14. FATHER'S NAME First Middle Last John Coffin	15. MOTHER'S MAIDEN NAME First Middle Last Grace Evelyn Allen				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 173057521	17. INFORMANT Address James Lynch, Jr., Denton, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Emphysema DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1984 , to 1986 , that (I) (we) last saw the deceased alive on 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE P. Gregg Rhodes	DEGREE M. D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type) P. Gregg Rhodes, M. D.		22e. ADDRESS 503 Dutchmens Lane, Easton, MD			
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 7/26/86	23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery	23d. LOCATION (City or Town) (County) (State) Denton Caroline MD		
24. FUNERAL DIRECTOR Maere Funeral Home, P.A. Denton, Md.		ADDRESS	REC'D BY REGISTRAR JUL 31 1986	25b. REGISTRAR'S SIGNATURE John E. Rhodes	



00-14730

14

6

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR CERTIFICATE OF DEATH					REG. NO. 21266				
1. DECEASED NAME (TYPE OR PRINT) EDWARD RICHARD MORRIS					2a. DATE OF DEATH MONTH DAY YEAR 7 26 86				
3 SEX MALE		4 RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		2b. HOUR 12:35 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FURNITURE REFINISHER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 211 SEYMOUR AVE. 21663	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN MORRIS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE SHORES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW II 216-18-2397		17. INFORMANT ADDRESS 211 SEYMOUR AVE. FRANCES L. MORRIS / ST. MICHAELS, Md 21663					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Arrhythmias DUE TO, OR AS A CONSEQUENCE OF Coronary Artery Disease + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF Previous Myocardial Infarction (c) 2 mos									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7/26 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 403 MARVEL CT. EASTON MD 21601					
22a. I certify that (1) this hospital attended the deceased from 7/26 1986 to 7/26 1986 , that (1) (we) last saw the deceased alive on 7/26 1986 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.									
22b. SIGNATURE Scott D. Friedman MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/27/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT D. FRIEDMAN MD					22e. ADDRESS 403 MARVEL CT. EASTON MD 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 29, 1986		23c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ST. MICHAELS, TALBOT MARYLAND			
24. FUNERAL DIRECTOR NAME Sharon E. Leonard St. Michaels Md					25a. DATE REC'D. BY REGISTRAR AUG 04 1986		25b. REGISTRAR'S SIGNATURE Julia Denton-Rodgers		

MEMORANDUM

Subject

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

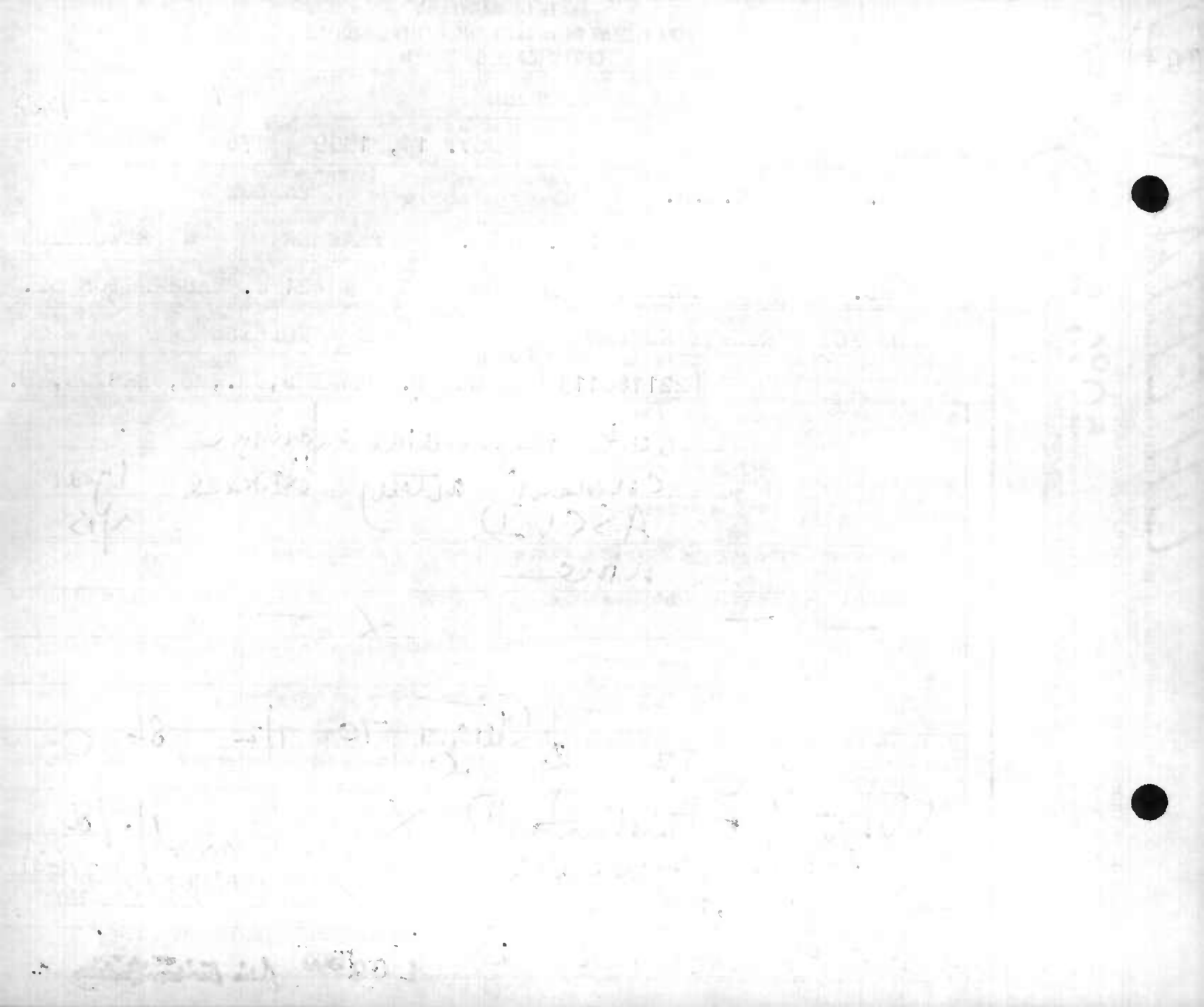
9. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) MARY THARP NUTTLE			2a. DATE OF DEATH Month 7 Day 2 Year 86			2b. HOUR 4:45 PM				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH NOV. 14, 1909		6. AGE (In years lost in day) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH TALBOT				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 421 S. WASH.			12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) TELEPHONE			12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 421 S. WASHINGTON ST.	
14. FATHER'S NAME First Middle Last FREDERICK BURGETTE NUTTLE				15. MOTHER'S MAIDEN NAME First Middle Last MARY HOPKINS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, age, or unknown) NO			16b. SOCIAL SECURITY NO. 221160113		17. INFORMANT Address ALBERT T. DAWKINS, JR., MD, EASTON, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year 4/5	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) none										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) —					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) —			21f. LOCATION Street or R.F.D. No. City or Town County State Route 70 1/2 86					
22a. I certify that (I) (this hospital) attended the deceased from July 2, 1986 to 7/2 , 19 86 , that (I) (we) last saw the deceased alive on 7/2 , 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Albert T. Dawkins Jr.					22c. DATE SIGNED 7/5/86		22d. PHYSICIAN'S NAME (Type) ALBERT T. DAWKINS JR.			
22e. ADDRESS Route 5 Box 307 EASTON MARYLAND 21601					22f. LOCATION (If not in home) (State) DENTON CAROLINE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) —		23b. DATE JULY 5, 1986		23c. NAME OF CEMETERY OR CREMATORY DENTON CEMETERY			23d. LOCATION (If not in home) (State) DENTON CAROLINE MD			
24. FUNERAL DIRECTOR RANDOLPH P. MOORE DENTON, MD.					25a. REC'D BY REGISTRAR DL 09/1986		25b. REGISTRAR'S SIGNATURE Jim Simon			



00-14310

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

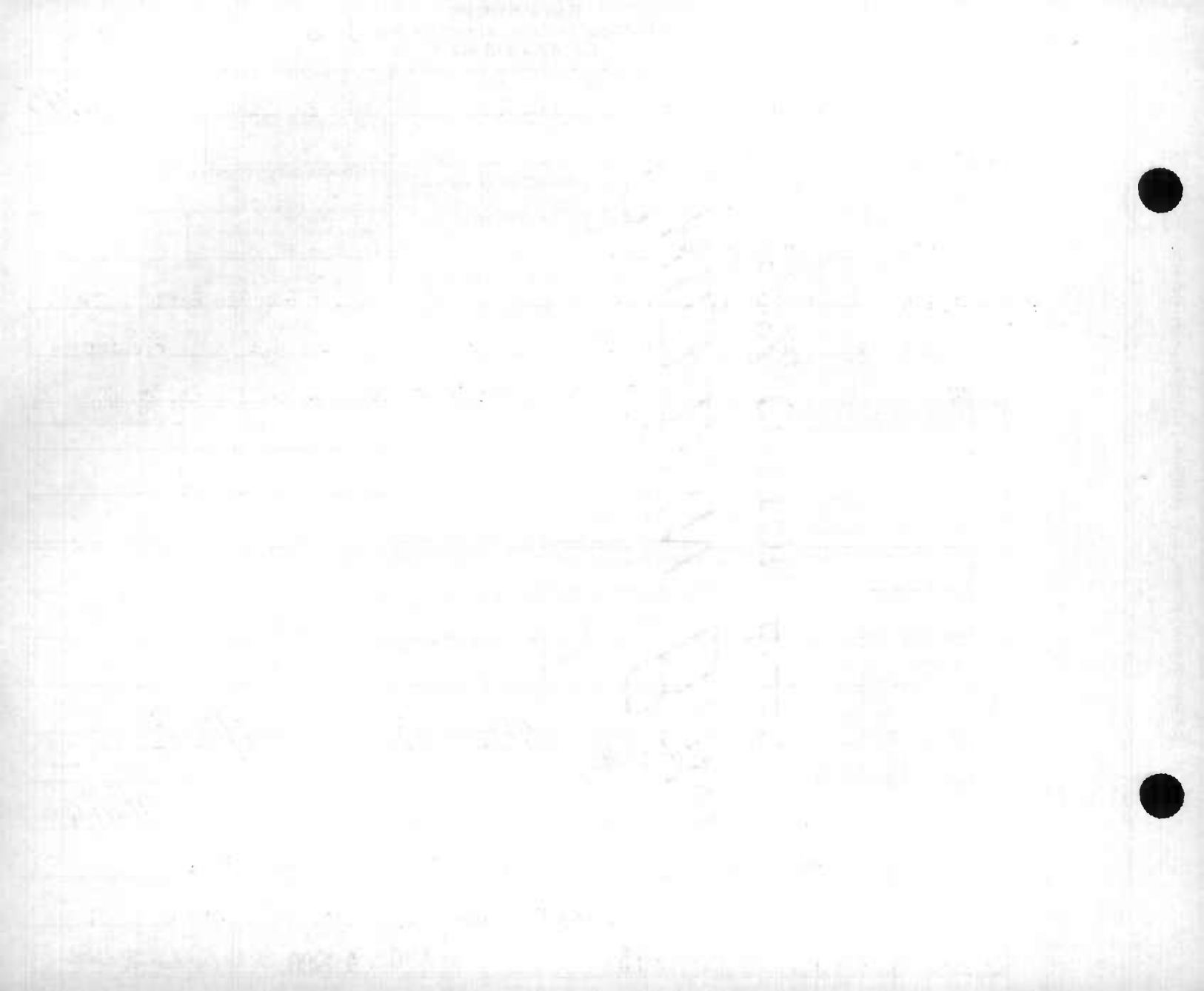
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1- FOR STATE REGISTRAR CERTIFICATE OF DEATH										6 21268	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES E. PRICE					2a. DATE OF DEATH MONTH DAY YEAR July 30, 1986			2b. HOUR 6:45			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 02 96		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (CITY OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) R.D. 6 Box 116				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE R.D. 6 Box 116 Easton 21601		
14. FATHER'S NAME FIRST MIDDLE LAST Willard S. Russell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Eugenia Fleming								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-74-9894		17. INFORMANT ADDRESS James H. Price RD 6 Box 116 Easton MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2/19/86 2:38 P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) R3					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7/30/86					
22a. I certify that (I) (this hospital) attended the deceased from 2/19/86 to 7/30/86 , that (I) (we) lost saw the deceased alive on 2/19/86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE OF PHYSICIAN George B. Cavangh MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/31/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Cavangh, M.D.						22e. ADDRESS Commerce Dr., Easton MD 21601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/2/86		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home						25a. DATE REC'D. BY REGISTRAR AUG 4 1986			25b. REGISTRAR'S SIGNATURE L. Davidson-Randall		



00-13043

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon pages. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 6 2 1 2 6 9					
1. DECEASED NAME (TYPE OR PRINT) <i>Harry Clay Reynolds</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>7-16-86</i>				2b. HOUR <i>7:00</i> M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>03 21 1912</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.					
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Gen Mgr-Hotel</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Rt 7, Box 163 21601</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Clay Reynolds</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Brooks</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>YES</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW II</i>		17. INFORMANT ADDRESS <i>Louisa B. Reynolds Rt 7 Box 163 Easton MD</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of Prostate</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>7/16</i> , 19 <i>86</i> , to <i>7/16</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>7/16</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wm H Wood Jr</i>						DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>7/16/86</i>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wm H Wood Jr</i>						22e. ADDRESS <i>EASTON MD 21601</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>				23b. DATE <i>7/17/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Salisbury Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salisbury Wic. MD</i>			
24. FUNERAL DIRECTOR NAME <i>Newman Funeral Home</i>						ADDRESS <i>Easton MD 21601</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 21 1986</i>			
						25b. REGISTRAR'S SIGNATURE <i>J. Davidson</i>					

BP

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0-13947

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without delay after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 21270

1. DECEASED NAME (TYPE OR PRINT) ALBERT G. ROBINSON			2a. DATE OF DEATH MONTH DAY YEAR July 24 1986			2b. HOUR MIN. 12 45 M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 27 94		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.				
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Tire & Battery		
13a. STATE Maryland			13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 24 N. Harrison St. 21601	
14. FATHER'S NAME FIRST MIDDLE LAST William F. Robinson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Murphy			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				
16b. SOCIAL SECURITY NO. 232-01-6325			17. INFORMANT ADDRESS A. Earle Robinson RD 1 Box 78 Easton MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SMALL BOWEL OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (b) ADHESIONS DUE TO, OR AS A CONSEQUENCE OF (c) ADHESIONS Approximate interval between onset and death: 4 MONTHS 4 MONTHS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CAROTID VASCULAR INSUFFICIENCY										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6/2/86 19, to 7/24/86 19, that (I) (we) last saw the deceased alive on 7/23/86 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C. R. W. BAIN			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/24/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. W. BAIN			22e. ADDRESS Easton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 26 1986		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Easton Talbot MD			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			25a. DATE REC'D. BY REGISTRAR JUL 28 1986			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

00-14891

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR 72 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21271
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) M. Catherine			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 29 86			2b. DATE OF DEATH MONTH DAY YEAR 7 29 86			2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 29 86			
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 1 16 03	6. AGE (IN YEARS) LAST BIRTHDAY 83 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot						
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		11. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) homemaker				12b. KIND OF BUSINESS OR INDUSTRY home				
13a. STATE Maryland		13b. CITY OR TOWN Caroline		13c. CITY OR TOWN Goldsboro		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS State Rt. 312 21636				
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Pinder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M. Catherine Rimmer			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, YES, NO, OR UNKNOWN) no						
16b. SOCIAL SECURITY NO. 213-10-3902			17. INFORMANT Shirley E. Story Goldsboro, MD									
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery, Heart Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old Cerebral Vascular Disease</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>old Cerebral Vascular Disease</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE R. E. Boulais			M.D. (SPECIFY)			MEDICAL EXAMINER			DATE SIGNED 7-30-86			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 8-2-86		23c. NAME OF CEMETERY OR CREMATORY Ridgely Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Ridgely CA MD				
24. FUNERAL DIRECTOR NAME John E. Boulais			ADDRESS Greensboro, MD			25a. DATE REC'D. BY REGISTRAR AUG 4 1986			25b. REGISTRAR'S SIGNATURE John E. Boulais			

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

1895
1896
1897

1898

1899

James M. Smith
President

Secretary

James M. Smith
President

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-15180

DHMH - 16 50M 1/76
(VR A 15 (4))

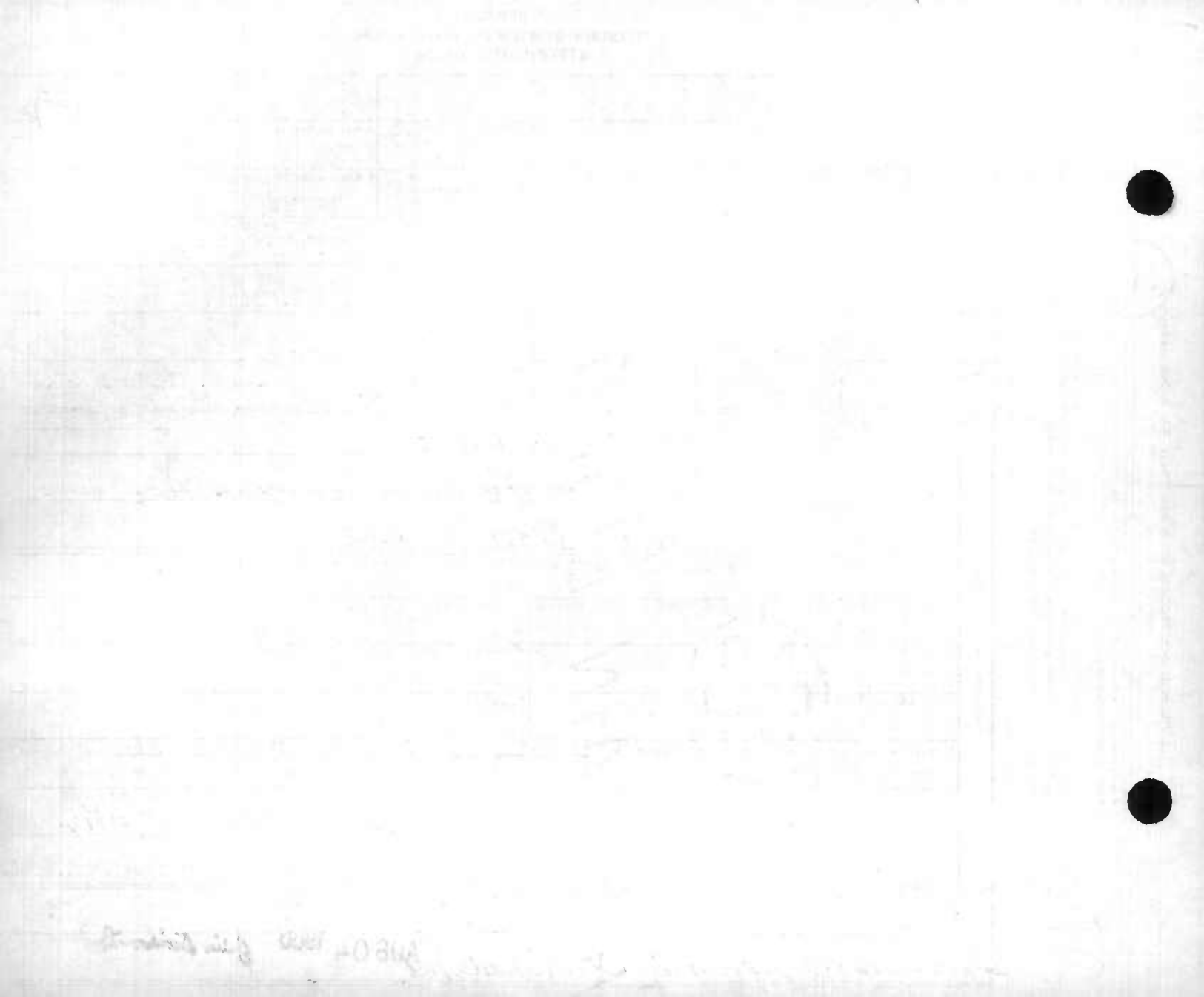
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (circled).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISABEL BUTLER THOMAS					2a. DATE OF DEATH MONTH DAY YEAR JULY 27, 1986			2b. HOUR 7:58 PM		
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 1, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.				
10. CITY OR TOWN OF DEATH ST. MICHAELS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 103 E. CHEW AVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. DEPT OF AGRICULTURE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND					13b. COUNTY TALBOT		13c. CITY OR TOWN ST. MICHAELS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CORNELIUS THOMAS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MOLLIE WILLIAMS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-32-0910A		17. INFORMANT ESTHER T. LARRIMORE		ADDRESS 120 W. CHESTNUT ST. ST. MICHAELS, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC BRAIN SYNDROME										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (i) (this hospital) attended the deceased from 8/10 , 19 81 , to 6/24 , 19 86 , that (ii) (we) last saw the deceased alive on 1/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. S. Bremer				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/27/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM S. BREMER M.D.				22e. ADDRESS 103 E. CHESTNUT ST. ST. MICHAELS, Md. 21663						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JULY 30, 1986		23c. NAME OF CEMETERY OR CREMATORY OLIVET CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ST. MICHAELS, TALBOT MD				
24. FUNERAL DIRECTOR NAME Harrison E. Leonard				25. DATE OF DEATH AUG 04 1986		26. SIGNATURE [Signature]				

MEDICAL CERTIFICATION



04-14410

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 21273

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elma G Trice			2a. DATE OF DEATH MONTH DAY YEAR 7/20/86		2b. HOUR 9:45 AM				
3. SEX Female		4. RACE Cal.		5. DATE OF BIRTH MONTH DAY YEAR May 24, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Caroline						13c. CITY OR TOWN Federalsburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Moore						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Catherine Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-38-0622		17. INFORMANT ADDRESS Linwood F. Trice Sr. Fed., Md. 21632					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old Myocardial Infarct</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a)

Diabetes

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>7/20/86</u> to <u>7/20/86</u> , that (I) (we) lost saw the deceased alive on <u>7/20/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Phyllis Black</u>				DEGREE <u>MD</u>		22c. DATE SIGNED <u>7/20/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Phyllis Black Rhodes</u>				22e. ADDRESS <u>503 Dutchman's Lane, Easton 21601</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-23-86		23c. NAME OF CEMETERY OR CREMATORY Concord Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalsburg Caroline Md. 21632	
24. FUNERAL DIRECTOR NAME <u>Harvey W. Weaver - Federalsburg Md.</u>				25. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Julia Benson-Rodner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										6 2 1 2 7 4	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUTH MERRIAM VIAL						2a. DATE OF DEATH MONTH DAY YEAR 7-7-86			2b. HOUR 1:05a M		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11 - 26 - 89		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		IF UNDER 1 YEAR MONTHS DAYS 96		IF UNDER 24 HRS HOURS MIN. 96	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.					
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDAN NURSING CENTER-THE PINES				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Hovey Merriam						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Howard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-8375		17. INFORMANT ADDRESS Ruth V. Hogue Easton, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROGRESSIVE CEREBRAL ATHEROSCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 2-7 19 84 to 7-7 19 86 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Stephen P. Carney</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-7-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN P. CARNEY, M.D.						22e. ADDRESS EASTON, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 7-7-86		23c. NAME OF CEMETERY OR CREMATORY salisbury crematory		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME ADDRESS NEWNAM FUNERAL HOME, EASTON, MARYLAND						25a. DATE REC'D. BY REGISTRAR JUL 9 1986		25b. REGISTRAR'S SIGNATURE <i>J. A. Davidson</i>			

MEDICAL CERTIFICATION

BP



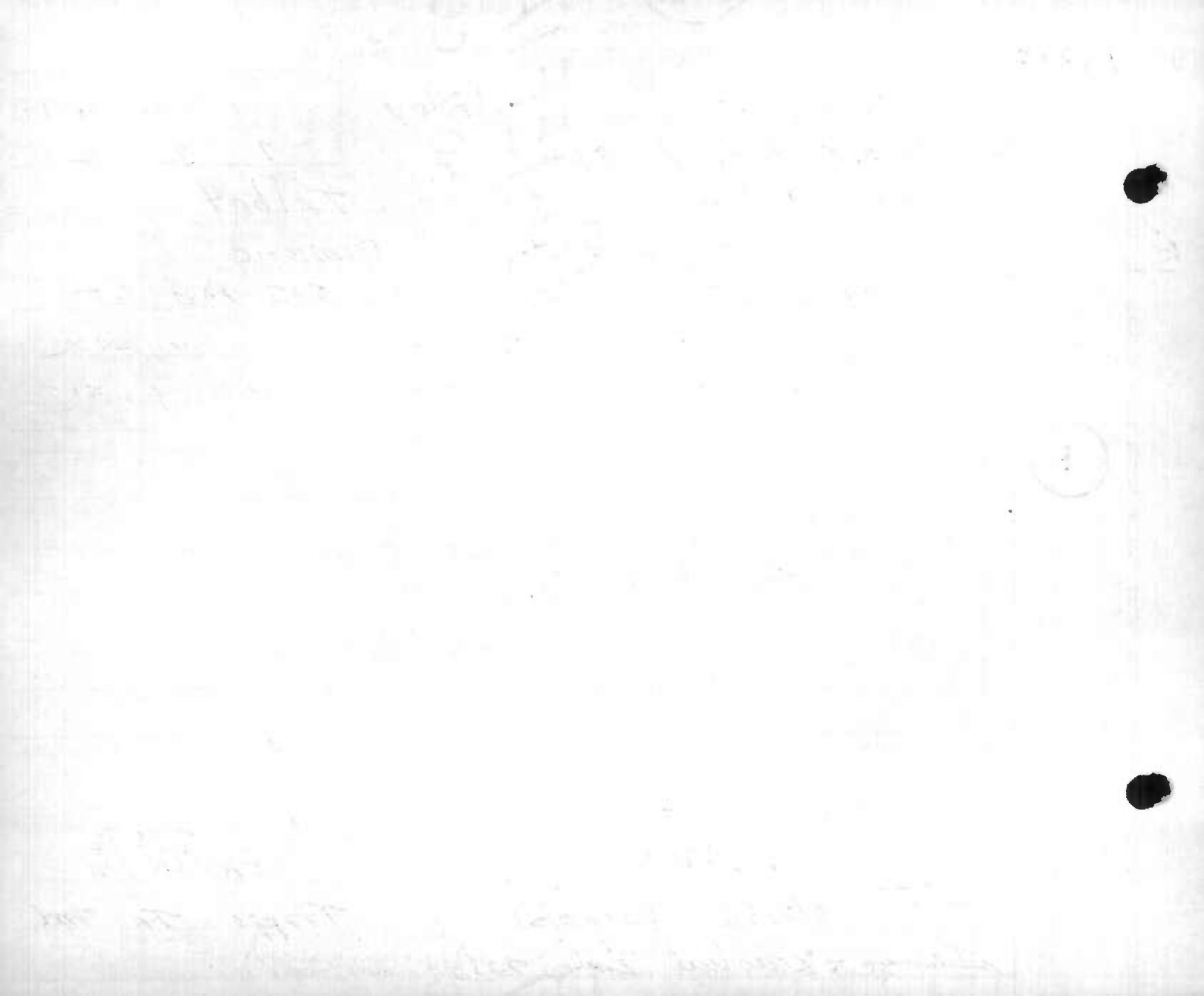
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00 HEALTH 31 SEP 86
FOR STATE
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MD. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) First Middle Last <i>Margaret M. Walley</i>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>7-30 1986</i>		2b. HOUR <i>9A M</i>			
3. SEX <i>Female</i>		4. RACE <i>BLK</i>		5. DATE OF BIRTH <i>6/9/04</i>		6. AGE (In years last birthday) <i>82</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month <i>7</i> Day <i>30</i> Year <i>1986</i>		2d. HOUR <i>1P M</i>	
7a. BIRTHPLACE (State or foreign country) <i>md</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.			
10. CITY OR TOWN OF DEATH <i>Easton</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>205 Post St.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Domestic</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md</i>				13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>205 Post St</i>	
14. FATHER'S NAME First Middle Last <i>John Nixon</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Mamie Wilson</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16b. SOCIAL SECURITY NO. <i>214-28-1679</i>		17. INFORMANT <i>Walter Walley Sr.</i>				ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>H. C.-V. D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Heart xxxxxxxxxxxx per A. D.</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
Cert. approved by Dr. <i>Nixon</i> ACTUAL SIGNATURE <i>Louis S. Welty</i> M.D. EXAMINER'S NAME (Type) <i>Louis S. Welty</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) <i>EASTON MD</i>		22b. DATE SIGNED <i>7-30-86</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>8/2/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>paradise</i>		23d. LOCATION (City or Town) (County) (State) <i>Trapp Talbot Md</i>					
24. FUNERAL DIRECTOR <i>George H. Daslund</i> <i>Easton md</i>						25a. REC'D BY REGISTRAR DATE <i>AUG 13 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			



00-11828

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 6 21276

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lavelette Hughes WINFREY		2a. DATE OF DEATH MONTH DAY YEAR July 6, 1986		2b. HOUR 4:55 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR September 6, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Queen Anne's	13c. CITY OR TOWN Wye Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Thomas Hughes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lola Balzora Preble		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-42-5800	17. INFORMANT Daughter Mrs. Mattie W. Denny, Wye Mills, Md. 21679		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) COPD with aortic fibrosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 month years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Gastrointestinal hemorrhage, Peptic ulcer disease				
19a. DATE OF OPERATION + carcinoma of vocal cords	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10 7/6 86	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE -80 7/6 86		
22a. I certify that (I) (this hospital) attended the deceased from 7/6 86 to 7/6 86 that (I) (we) last saw the deceased alive on 7/6 1986 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)				
22b. SIGNATURE Albert T. Denny M.D.		22c. DATE SIGNED 7/6/86		22d. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Albert T. Denny M.D.		22f. ADDRESS Route 2, Box 117, Easton, Maryland 21601		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE July 8, 1986	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md.	
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR JUL 09 1986		
		25b. REGISTRAR'S SIGNATURE Julia Denny		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



RECEIVED - 11/11/1911

September 1, 1911

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00-14309

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 1 2 7 7

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Edith Wright			2a. DATE OF DEATH MONTH DAY YEAR 7 28 86			2b. HOUR 6 50 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		8b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Health Plannin	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Dorchester		13d. CITY OR TOWN Cambridge		13e. STREET ADDRESS / ZIP CODE 2 Belvedere Ave. 21613		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. GROFF			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELLE JONES						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-16-8037		17. INFORMANT ADDRESS Mr. Frank Wright, same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Breast cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/86</u> to <u>7/28/86</u> , that (I) (we) last saw the deceased alive on <u>7/28/86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Stephan Carney</u>					DEGREE		22c. DATE SIGNED 7-29-86		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephan Carney, M.D.					22e. ADDRESS Easton, Maryland 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-31-86		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md.		
24. FUNERAL DIRECTOR NAME Curran Funeral Home					308 High St. ADDRESS Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR AUG 4 1986		25b. REGISTRAR'S SIGNATURE <u>Jana Christian</u>

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed by the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in advance.

00-1-00

